STATE OF MICHIGAN
STATE OFFICE OF ADMINISTRATIVE HEARINGS AND RULES
FOR THE DEPARTMENT OF COMMUNITY HEALTH
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IN THE MATTER OF:

[redacted],

Appellant
_____/

Docket No. 2009-5834 HHS
Case No. [redacted]
Load No. [redacted]

DECISION AND ORDER

This matter is before the undersigned Administrative Law Judge pursuant to MCL 400.9 and 42 CFR 431.200 *et seq.,* upon the Appellant's request for a hearing.

After due notice, a hearing was held on [redacted], Appellant's daughter/representative/provider, appeared and testified on Appellant's behalf. [redacted] (Appellant) appeared at the hearing and testified. [redacted] represented the Department. [redacted], appeared and testified as a witness for the Department.

ISSUE

Did the Department properly determine that Appellant was no longer eligibility for eligible for Home Help Services (HHS)?

FINDINGS OF FACT

The Administrative Law Judge, based upon the competent, material and substantial evidence on the whole record, finds as material fact:

1. Appellant is a [redacted] year-old Medicaid recipient who had been receiving HHS.

2. Appellant was living with her daughter/provider and grandchild at all times relevant to this matter.

3. Appellant was receiving HHS for assistance with bathing, grooming, dressing, medication, housework, laundry, shopping for food/meds, and meal preparation. (Exhibit 1, p. 8)

4. On [redacted], the [redacted], went to Appellant's home to reassess her eligibility for HHS. (Exhibit 1, p. 7)

5. During the reassessment in [redacted], the worker noted the following: Appellant and her grandson were present, and Appellant said she forgot about the home call; Appellant said that her provider/daughter was at work, and she was babysitting for her [redacted] year-old grandson; the worker called Appellant's provider who stated that she works full time all day, Monday through Saturday, and the provider was evasive when she was asked if Appellant babysat daily; Appellant's provider said that Appellant takes care of her grandson on a regular basis; Appellant's apartment was in total disarray and appeared to not have been cleaned in a while; and Appellant appeared to have improved and be able to provide for her own care and the care of her grandson throughout the day. (Exhibit 1, p. 7)

6. After the reassessment in [redacted] determined that Appellant's HHS case should close on the basis that she no longer needed assistance with her activities of daily living. (Exhibit 1, p. 7)

7. On [redacted] sent a negative action notice to Appellant, stating that her HHS were being terminated because she is no longer in need of personal care assistance. (Exhibit 1, pp. 2 & 4)

8. On [redacted] the State Office of Administrative Rules received Appellant's hearing request, protesting the termination.

CONCLUSIONS OF LAW

The Medical Assistance Program is established pursuant to Title XIX of the Social Security Act and is implemented by Title 42 of the Code of Federal Regulations (CFR). It is administered in accordance with state statute, the Administrative Code, and the State Plan under Title XIX of the Social Security Act Medical Assistance Program.

Home Help Services (HHS) are provided to enable functionally limited individuals to live independently and receive care in the least restrictive, preferred settings. These activities must be certified by a physician and may be provided by individuals or by private or public agencies.

COMPREHENSIVE ASSESSMENT

The Adult Services Comprehensive Assessment (FIA-324) is the primary tool for determining need for services. The comprehensive assessment will be completed on all open cases, whether a home help payment will be made or not. ASCAP, the automated workload management system provides the format for the comprehensive assessment and all information will be entered on the computer program.

Requirements for the comprehensive assessment include, but are not limited to:

- A comprehensive assessment will be completed on all new cases.
- A face-to-face contact is required with the customer in his/her place of residence.
- An interview must be conducted with the caregiver, if applicable.
- Observe a copy of the customer's social security card.
- Observe a picture I.D. of the caregiver, if applicable.
- The assessment must be updated as often as necessary, but minimally at the six month review and annual re-determination.
- A release of information must be obtained when requesting documentation from confidential sources and/or sharing information from the agency record.
- Follow specialized rules of confidentiality when ILS cases have companion APS cases.

Functional Assessment

The **Functional Assessment** module of the **ASCAP** comprehensive assessment is the basis for service planning and for the HHS payment.

Conduct a functional assessment to determine the customer's ability to perform the following activities:

Activities of Daily Living (ADL)

- Eating
- Toileting
- Bathing
- Grooming

- Dressing
- Transferring
- Mobility

Instrumental Activities of Daily Living (IADL)

- Taking Medication
- Meal Preparation and Cleanup
- Shopping for food and other necessities of daily living
- Laundry
- Housework

Functional Scale ADL's and IADL's are assessed according to the following five-point scale:

1. Independent
   Performs the activity safely with no human assistance.

2. Verbal Assistance
   Performs the activity with verbal assistance such as reminding, guiding or encouraging.

3. Some Human Assistance
   Performs the activity with some direct physical assistance and/or assistive technology.

4. Much Human Assistance
   Performs the activity with a great deal of human assistance and/or assistive technology.

5. Dependent
   Does not perform the activity even with human assistance and/or assistive technology.

Note: HHS payments may only be authorized for needs assessed at the 3 level or greater. Customers must require assistance with at least one qualifying ADL in order to qualify for HHS payments. A qualifying ADL (functionally assessed at Level 3 or greater) would include:

- An ADL functional need authorized by the worker
- An ADL accomplished by equipment or assistive technology and documented by the worker, or

- An ADL functional need performed by someone else, requiring no Medicaid reimbursement, or
- A request authorized as necessary through an exception made by the Department of Community Health, Central Office.

Once an ADL has been determined or exception request has been granted, the customer is then eligible for any ADL or IADL authorized home help service.

Adult Services Manual (ASM)363, 6-1-2007

Service Plan Development

Address the following factors in the development of the service plan:

- The specific services to be provided, by whom and at what cost.
- The extent to which the customer does not perform activities essential to caring for self. The intent of the Home Help program is to assist individuals to function as independently as possible. It is important to work with the recipient and the provider in developing a plan to achieve this goal.
- The kinds and amounts of activities required for the customer's maintenance and functioning in the living environment.
- The availability or ability of a responsible relative or legal dependent of the customer to perform the tasks the customer does not perform. Authorize HHS **only** for those services or times which the responsible relative/legal dependent is unavailable or unable to provide.
- Do **not** authorize HHS payments to a responsible relative or legal dependent of the customer.
- The extent to which others in the home are able and available to provide the needed services. Authorize HHS **only** for the benefit of the customer and **not** for others in the home. If others are living in the home, prorate the IADL's by at least 1/2, more if appropriate.
- The availability of services currently provided free of charge. A written statement by the provider that he is no longer able to furnish the service at no cost is sufficient for payment to be authorized as long as the provider is not a responsible relative of the customer.

- HHS may be authorized when the customer is receiving other home care services if the services are not duplicative (same service for same time period).

Adult Services Manual (ASM)363, 6-1-2007

ELIGIBILITY FOR HOME HELP SERVICES

Home help services (HHS) are defined as those, which the Agency is paying for through Title XIX (Medicaid) funds. The customer must be eligible for Medicaid in order to receive these services.

Medicaid/Medical Aid (MA)

Verify the customer's Medicaid/Medical aid status.

The customer may be eligible for MA under one of the following:

- All requirements for MA have been met, **or**
- MA spend-down obligation has been met.

Adult Services Manual (ASM)363, 6-1-2007

Medicaid Personal Care Option

Customers in need of home help personal care services may become eligible for MA under the Medicaid personal care option.

Discuss this option with the customer and the ES.

Conditions of eligibility:

- The customer meets all MA eligibility factors except income.
- An ILS services case is active on CIMS (program 9).
- The customer is eligible for personal care services.
- The cost of personal care services is **more** than the MA excess income amount.
- The customer agrees to pay the MA excess income amount to the home help provider.

Inform the ES of the amount of personal care services (HHS care cost) **and** the amount of personal care required but not approved for HHS payment, i.e., monthly payment does not meet total care needs.

If **all** the above conditions have been met, the customer has met MA spend-down requirements. The ES will send written notification of the MA effective date and the MA excess income amount.

Upon receipt of the ES notification, enter the customer's spend-down amount in **the Resources** tab of the **Basic Customer** module in **ASCAP**.

Note: Use the Services Approval Notice (FIA-1210) to notify the customer of HHS approval when MA eligibility is met through this option. The notice must inform the customer that the HHS payment will be affected by the spend-down amount, and that the customer is responsible for paying the provider the MA excess income amount (spend down) each month.

Do **not** close a case eligible for MA based on this policy option if the customer does not pay the provider. It has already been ensured that MA funds will not be used to pay the customer's spend-down liability. The payment for these expenses is the responsibility of the customer.

Notify the ES in writing of any changes in the customer's personal care needs. The ES will send written notification of any changes in the monthly MA excess income amount.

MA eligibility under this option **cannot** continue **if:**

- The customer no longer needs personal care; **or**
- The cost of personal care becomes **equal to or less than** the MA excess income amount.

Note: See Program Eligibility Manual (PEM) 545, Exhibit III, regarding the Medicaid Personal Care Option.

Necessity For Service

The adult services worker is responsible for determining the necessity and level of need for HHS based on:

- Customer choice.

- A complete comprehensive assessment and determination of the customer's need for personal care services.

- Verification of the customer's medical need by a Medicaid enrolled medical professional. The customer is responsible for obtaining the medical certification of need. The Medicaid

provider identification number must be entered on the form by the medical provider. The Medical Needs form must be signed and dated by one of the following medical professionals:

- Physician
- Nurse Practitioner
- Occupational Therapist
- Physical Therapist

The physician is to certify that the customer's need for service is related to an existing medical condition. The physician does not prescribe or authorize personal care services.

If the Medical Needs form has not been returned, the adult services worker should follow-up with the customer and/or medical professional.

Adult Services Manual (ASM)363, 6-1-2007

HOME HELP SERVICE PROVIDERS

Provider Selection

The customer has the right to choose the home help provider(s). As the employer of the provider, the customer has the right to hire and fire providers to meet individual personal care service needs.

The customer may receive FIA payment for home help services from **qualified** providers only.

The determination of provider qualification is the responsibility of the adult services worker.

Upon request, the adult services worker should assist the customer in obtaining a qualified provider.

The local office may maintain a resource file of qualified providers willing to assist HHS customers. The file may include such information as:

- Type of customer the provider is willing to work with;
- Training the provider has participated in;
- Past work experience;
- Hours the provider is willing/available to work;
- Type of services the provider is willing to perform.

Do not authorize HHS payments to a responsible relative or legal dependent of the customer.

Provider Criteria

Determine the provider's ability to meet the following minimum criteria in a face-to-face interview with the customer **and** the provider:

Age
- Appropriate to complete the needed service.

Ability
- To follow instructions and HHS program procedures
- To perform the services required
- To handle emergencies

Physical Health
- Adequate to perform the needed services

Knowledge
- How and when to seek assistance from appropriate others in the event of an emergency

Personal Qualities
- Dependable
- Can meet job demands including overtime, if necessary

Training
- Willing to participate in available training programs if necessary. HHS payment may be terminated if the provider fails to meet any of the provider criteria.

Provider Interview

Explain the following points to the customer and the provider during the initial interview:

- The provider is employed by the customer **not** the State of Michigan.
- A provider who receives public assistance **must** report all income received as a home help provider to the FIS/ES.
- The customer is the employer and has the right to hire and fire the provider.

- The customer is responsible for notifying the worker of any change in providers or hours of care.
- The services the provider is responsible for and has agreed to deliver including the frequency, amount and type of service.
- The provider **must** keep a log of the services provided Personal Care Services Provider Log (FIA-721) and submit it on a quarterly basis.
- The customer **must** sign the Authorization for Withholding of FICA Tax in Home Help Payments (FIA-4771).
- The customer **and** provider **must** sign the Home Help Services Statement of Employment (MSA-4676).

Providers considered as a business are exempt from signing the DCH-4676.

Provider Enrollment

Home help providers **must** be enrolled on the Model Payments System (MPS) prior to payment authorization. See the ASCAP user guide on the Adult Services home page for directions on enrolling a provider.

Personal Care Services Provider Log (FIA-721)

Each provider must keep a log of home help service provided. The FIA-721 is used for this purpose.

Indicate on the log which tasks the provider is approved to do based on the customer's HHS plan.

The provider must indicate what services were provided and on which days of the month.

The customer and the provider must sign the log when it is completed to verify that the services approved for payment were delivered.

The log must be submitted to the local office at least quarterly.

The adult services worker must initial and date the log upon receipt.

Retain the log in the customer's case record.

A separate log is required for each provider.

Other types of logs such as billings for services are acceptable in lieu of the FIA-721. Each bill must specify the service provided and the date(s) of service.

Home Help Services Statement Of Employment (MSA-4676)

The purpose of the Home Help Services Statement of Employment (MSA-4676) is to serve as an agreement between the customer and provider, which summarizes the general requirements of employment. The form is completed by the adult services worker as part of the provider enrollment process.

An employment statement must be signed by **each** provider who renders service to a customer.

The Statement:

- **Confirms an understanding of the personal care services provided, how often services are provided, and wages to be paid.**
- Requires positive identification of the provider by means of a picture ID.
- Documents an understanding by both parties that the customer, not the State of Michigan, is the employer of the provider.
- Stipulates that the customer must report any changes in the work schedule to the adult services worker.
- Instructs the provider to repay the State of Michigan for services he or she did not provide.
- Informs the provider that a Personal Care Services Provider Log (FIA-721) must be completed and returned to the worker on time to avoid delay in payment.
- Informs a provider receiving public assistance that this employment will be reported to the Family Independence Agency.
- The customer and provider must sign the MSA-4676 statement indicating their understanding of the terms of the agreement.

Distribution of Employment Statement

- The adult services worker will make **two copies** of the completed and signed form.
- Give one copy to the customer and one to the provider.
- Place the **original** form in the customer's case record.

PAYMENT AUTHORIZATION

Payment Authorization System
Enter home help provider enrollments and payment authorizations on the Model Payment System (MPS) using the **Payments** module of the **ASCAP** system.

No payment can be made unless the provider has been enrolled on the MPS provider database. See the ASCAP user guide on the Adult Services home page.

HHS payments to providers must be:

- Authorized for a specific type of service, period of time and payment amount.
- Authorized to the person actually providing the service.
- Made payable jointly to the customer and the provider.

Any payment authorization that does **not** meet the above criteria must have the reason fully documented in the **Payments** module, exception rationale box, in **ASCAP**. The supervisor will document through the electronic approval process.

Adult Services Manual (ASM) 363, 6-1-2007

REVIEWS

ILS cases must be reviewed every six months. A face-to-face contact is required with the customer, in the home. If applicable, the interview must also include the caregiver.

Six Month Review

Requirements

Requirements for the review contact must include:

- A review of the current comprehensive assessment and service plan.
- Completion of the Risk Assessment at the first six month review.
- Follow-up collateral contacts with significant others to assess their role in the case plan.
- Review of customer satisfaction with the delivery of planned services.

Annual Redetermination

Procedures and case documentation for the annual review are the same as the six month review, with the following additions:

Requirements

A reevaluation of the customer's Medicaid eligibility, if home help services are being paid for.

A new Medical Needs (FIA-54A) certification, if home help services are being paid for.

A face to face meeting with the care provider, if applicable. This meeting may take place in the office, if appropriate.

Adult Services Manual (ASM)363, 6-1-2007

TERMINATION OF HHS PAYMENTS

Terminate payments for HHS in any of the following circumstances:

The customer fails to meet any of the eligibility requirements.
The customer no longer wishes to receive HHS.
The customer's provider fails to meet qualification criteria.

When HHS are terminated or reduced for any reason, send a FIA-1212 to the customer advising of the negative action and explaining the reason. Continue the payment during the negative action period. Following the negative action period, complete a Payment Authorization on ASCAP to terminate payments.

If the customer requests a hearing before the effective date of the negative action, continue the payment until a hearing decision has been made. If the hearing decision upholds the negative action, complete the

> Payment authorization on ASCAP to terminate payments effective the date of the original negative action.
>
> *Adult Services Manual (ASM)362, 6-1-2007*

The Department took action to terminate Appellant's HHS case after the last reassessment of her HHS eligibility. During the reassessment in [redacted] the worker noted the following: Appellant and her grandson were present, and Appellant said she forgot about the home call; Appellant said that her provider/daughter was at work, and she was babysitting for her [redacted] year-old grandson; the worker called Appellant's provider who stated that she works full time all day Monday through Saturday, and the provider was evasive when she was asked if Appellant babysat daily; Appellant's provider did say that Appellant does take care of her grandson on a regular basis; Appellant's apartment was in total disarray and appeared to not have been cleaned in a while; and Appellant appeared to have improved and be able to provide for her own care and the care of her grandson throughout the day. The [redacted] testified that Appellant's apartment was extremely dirty, and it was the same way at the time of the previous assessment. In addition, [redacted] testified that Appellant's provider was not very cooperative in answering her questions about Appellant's ability to do activities of daily living.

Appellant's daughter/provider, [redacted] denied that Appellant's home was dirty, and claimed that she must do everything for her mother. When this Administrative Law Judge questioned her about Appellant's ability to care for a toddler while she worked during the day, she claimed that Appellant does not baby-sit all of the time, and when she does it is only from 6 a.m. to 8 or 9 a.m. while the child is still asleep. [redacted] testified that she picks her son up from Appellant's home in the morning and takes him with her to work. After [redacted] testified that the last home call reassessment was done between 12 & 3 p.m., Appellant's provider claimed that on that particular day she picked her son up later in the day, and there was another adult sleeping in another room of Appellant's apartment at the time of the last home call visit. However, [redacted] testified that she did not observe any other adult in the home.

The HHS policy states clearly that the Adult Services Worker is responsible for determining the necessity and level of need for HHS. The Adult Services Worker did a HHS in accordance with Department policy and determined that Appellant was independent in her ability to do all of her activities of daily living (ADLS) and instrumental activities of daily living (IADLs). [redacted] testified that the decision to close Appellant's HHS case was based on an observation of her physical abilities demonstrated during the assessment, and statements made by Appellant and her provider. [redacted] testified that during the last home call visit, Appellant moved about freely and did not use an assistive device for ambulation. In addition, she testified that when Appellant's grandson tried to get into a box, Appellant was able to pick him up and prevent him from doing so without any problems. [redacted] testified the decision to close the case was also based on a determination that Appellant's provider

was not providing the services that she was being paid to provide. The Department is required to terminate HHS if the provider no longer meets the provider qualification criteria.

Appellant and her representative failed to provide the necessary evidence to refute the Adult Services Worker's HHS assessment. This Administrative Law Judge did not give the testimony of Appellant's provider, [redacted] much weight because it was inconsistent, self-serving and not credible. Accordingly, the Department's denial of Appellant's continued eligibility for HHS must be upheld.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that the Department acted properly in taking action to close Appellant's Home Help Services case.

IT IS THEREFORE ORDERED that:

The Department's decision is **AFFIRMED**.

Marya A. Nelson-Davis
Administrative Law Judge
for Janet Olszewski, Director
Michigan Department of Community Health

cc: [redacted]

Date Mailed: 3/12/2009

***** NOTICE *****

The State Office of Administrative Hearings and Rules may order a rehearing on either its own motion or at the request of a party within 30 days of the mailing date of this Decision and Order. The State Office of Administrative Hearings and Rules will not order a rehearing on the Department's motion where the final decision or rehearing cannot be implemented within 90 days of the filing of the original request. The Appellant may appeal the Decision and Order to Circuit Court within 30 days of the receipt of the Decision and Order or, if a timely request for rehearing was made, within 30 days of the receipt of the rehearing decision.